

THE CITY OF CHICOPEE, MASSACHUSETTS
DEPARTMENT OF HUMAN RESOURCES
274 FRONT STREET, CHICOPEE MA 01013

SCOTT SZCZEBAK
ACTING DIRECTOR

TEL. (413) 594-1510
FAX (413) 594-1513

IMPORTANT: OPEN ENROLLMENT INFORMATION

Please read the following important information regarding the open enrollment period for your health, life and vision insurance:

- The open enrollment period will be held from April 2nd – May 3rd and will cover your health, life, dental and vision insurance.
- All changes to your benefits must be made during the open enrollment period.
- Open enrollment information and materials will be available online through www.chicopeema.gov, under the Human Resources page.
- There will be no increases in co-payments or deductibles.
- There will be no addition or elimination of health plans. However, the Health New England Medicare Advantage plan will now be available to all retirees who reside in Hampden, Hampshire and Franklin counties.
- The Standard life insurance will conduct an open enrollment period for all voluntary and non-voluntary life insurance benefits for active employees only. Coverage will now be available for spouse and children.
- There will be several special meetings sponsored by Human Resources, Health New England and Blue Cross Blue Shield to discuss lower-cost or alternative options in health insurance available to you. You will receive a separate notice in the near future with the date, time and place of the events.
- Please remember to keep your personal information up-to-date if any changes occur to your contact information

All active municipal employees and municipal retirees should send their changes by May 3rd to:

**Chicopee City Hall
Human Resources
274 Front Street
Chicopee, MA 01013**

All active school employees should send their changes to:

**Chicopee Public Schools Administration
180 Broadway Street
Chicopee, MA 01020**

DISCLAIMER: All information contained in these documents is for estimation purposes only. For the complete and accurate details of premiums, co-pays, deductibles and benefits, please contact Human Resources, Blue Cross Blue Shield or Health New England directly. In no event shall the City of Chicopee, its agents or employees be held liable for any damages stemming from the use of these estimates

HEALTH NEW ENGLAND

<u>Health New England New Rates</u>			
Family Plans			
	Total Premium	Emp. Monthly	Emp. Bi-Weekly
7H	\$1,205.24	\$482.10	\$241.05
7M	\$1,143.19	\$457.28	\$228.64
8H	\$1,088.45	\$435.38	\$217.69
9H	\$1002.43	\$400.97	\$200.49
PPO	\$1,697.17	\$848.59	\$424.29
Individual Plans			
	Total Premium	Emp. Monthly	Emp. Bi-Weekly
7H	\$449.40	\$134.82	\$67.41
7M	\$426.26	\$127.88	\$63.94
8H	\$405.86	\$121.76	\$60.88
9H	\$373.78	\$112.13	\$56.07
PPO	\$632.83	\$316.42	\$158.21

BLUE CROSS BLUE SHIELD

<u>Blue Cross Blue Shield Rates</u>			
Family Plans			
	Total Premium	Emp. Monthly	Emp. Bi-Weekly
Blue Value	\$1,662.96	\$665.18	\$332.59
Option V2	\$1,423.25	\$569.30	\$284.65
Individual Plans			
	Total Premium	Emp.Monthly	Emp. Bi-Weekly
Blue Value	\$639.88	\$191.96	\$95.98
Option V2	\$547.59	\$164.28	\$82.14

DENTAL

<u>Blue Cross Blue Shield Dental Rates</u>			
	Total Premium	Emp. Monthly	Emp. Bi-Weekly
Individual Plans:	\$34.00	\$17.00	\$8.50
Family Plans:	\$96.60	\$48.30	\$24.15

EYEMED VISION INSURANCE

The EyeMed Vision Care plan only covers the cost of eyewear and materials. Health New England and Blue Cross Blue Shield both offer vision examinations as part of their regular benefits package.

<u>EyeMed Vision Insurance Monthly Employee Cost</u>		
Employee: \$5.63	Employee +1: \$10.70	Family: \$15.71

FREQUENTLY ASKED QUESTIONS

What happens if I am retired and turning 65?

Three months prior to the 1st day of your birthday month you must contact Social Security to determine if you are eligible for Medicare Part B, either by yourself or through your spouse. If you are eligible for Medicare Part B, you must enroll in it to continue receiving insurance benefits from the City.

The City of Chicopee has adopted Chapter 32B Section 18 which requires retirees who are eligible to participate in Medicare Part B. This section states that you must verify and enroll in Medicare Part B to continue coverage on the City's plan. Once you become Medicare eligible you must obtain and complete paperwork from Human Resources.

We are planning to have a child in the next 6 months. When do I enroll him/her?

You have 30 days from the date of the birth of the baby/adoption to enroll him/her. You are also allowed to enroll your spouse and/or children at this time. You must fill out an enrollment form and include the Registration of Birth form or the Birth Certificate. Coverage is retroactive to the date of the birth of the baby and you will be charged accordingly.

I'm getting married next year. What should I do to ensure coverage for my future spouse?

You have 30 days from the date of marriage to enroll a spouse. You must fill out an enrollment form and include a marriage certificate. Coverage is retroactive to the date of marriage. You will be charged accordingly.

I recently lost my coverage that I received through a spouse. Can I enroll?

You have 30 days from the date of the loss to enroll. You must fill out an enrollment form and provide the HIPPA certificate to enroll. Coverage is retroactive and you will be charged accordingly.

OPEN ENROLLMENT: LIFE INSURANCE

The City has arranged for another open enrollment for the following life benefits with the Standard Life Insurance Company for **Active** employees and their dependents only.

NEW COVERAGE AVAILABLE FOR SPOUSE AND CHILDREN

I. Open Enrollment dates:

Completed forms **MUST** be returned to the Human Resource Dept. no later than May 3rd.

II. Basic Life & AD&D Benefit: \$20,000 (100% guaranteed issue)

The monthly cost of the Basic Life Benefit is paid 50% by the city and 50% by the employee. Monthly cost to the employee is \$7.60 for Basic Life/AD&D

III. Additional Life - Available in increments of \$10,000 up to a maximum of \$200,000

The first \$50,000 in additional life benefits is guaranteed issue, anything over \$50,000 is subject to underwriting / evidence of insurability

The Additional Life benefit is completely voluntary and is paid **100% by the employee**
Monthly cost to the employee is \$5.20 per each \$10,000 of Additional Life benefit.

IV. Life Coverage for Spouse and/or Child(ren)

This life coverage for spouse and/or child(ren) is voluntary and **100% paid by employee**
Spousal life coverage amount is \$10,000
Child(ren) coverage is \$5,000
Monthly cost to the employee is: \$5.40 per option

V. Contact information

For those who are interested in the Basic Life & AD&D or would like additional life insurance benefits, please contact Human Resources at (413) 594-1510

**ALL FORMS MUST BE FULLY COMPLETED
AND SUBMITTED BY MAY 3rd TO:**

**CITY OF CHICOPEE
HUMAN RESOURCES
274 FRONT STREET
CHICOPEE, MA 01013**



Please Read The Instructions
Before Filling Out This Form.

Enrollment and Change Form

Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an independent licensee of the Blue Cross and Blue Shield Association

Please PRINT CLEARLY using blue
or black ink to avoid coverage delay.

1. To Be Filled Out by Your Employer

Company Name		Current Medical Group #		Medical Group # Transferring To	
Current BCBS ID Number, if any		Requested Effective Date MM DD YYYY		Date of Hire MM DD YYYY	
Current Dental Group #		Dental Group # Transferring To			
Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CANCEL	(If canceling, please see instructions for three digit termination code.) <input type="text"/> <input type="text"/> <input type="text"/>	Remarks: (i.e., qualifying event for a new add, change to family, or further instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA <input type="checkbox"/> Change to Family <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent <input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other			

2. Tell Us About Yourself (Member 1)

What products are you selecting? <input type="checkbox"/> HMO Blue <input type="checkbox"/> Network Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Saver Product <input type="checkbox"/> Dental Blue <input type="checkbox"/> Access Blue <input type="checkbox"/> PPO <input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> Other (Write Name of Plan)	Kind of Membership (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family			
Your First Name	M.I.	Last Name	Sex	Date of Birth MM DD YYYY	
Street Address / P.O. Box #		Apt. #	City/Town	State	Zip Code
Social Security #	Telephone # (area code) ()	Other Insurance? * Y / N	Other Health Insurance Company Name		City/State
PCP ID #: (see instructions)	Name of PCP		City/State		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Are you Covered by Medicare? * Y / N	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #: <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	Actively Working Y / N If Retired, Date:

3. Tell Us About (Member 2)

Please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced Spouse (court ordered)					
Member 2's First Name	M.I.	Last Name	Sex	Date of Birth MM DD YYYY	
Street Address / P.O. Box #		Apt. #	City/Town	State	Zip Code
Social Security #	Telephone # (area code) ()	Other Insurance? * Y / N	Other Health Insurance Company Name		City/State
PCP ID #: (see instructions)	Name of PCP		City/State		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Is Member 2 Covered by Medicare? * Y / N	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #: <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	Actively Working Y / N If Retired, Date:

* If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

4. Tell Us About Your Dependents (Members 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. <input type="checkbox"/>

Please check if you are using separate forms for additional dependent children. ☐

Total # of Dependents: _____

5. Select Personal Savings Account (if applicable)

<input type="checkbox"/> HSA	Start Date	End Date	FSA GOAL AMOUNTS: (Please see instructions for maximum limits)
<input type="checkbox"/> FSA - Health	Start Date	End Date	
<input type="checkbox"/> FSA - Dep.	Start Date	End Date	
			Health \$:
			Dependent Care \$:

6. Signatures (Employer & Employee)

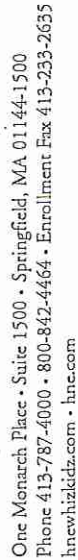
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature

Date

Employer's Signature

Date



PLEASE PRINT AND COMPLETE ALL INFORMATION

TYPE OF PLAN: ☐ HMO ☐ Advantage Plus (POS) ☐ PPO ☐ TYPE OF COVERAGE: ☐ INDIVIDUAL ☐ FAMILY ☐ OTHER

DATE OF HIRE: _____ HNE GROUP #: _____ EMPLOYER SIGNATURE: _____

DATE:

4/15/08 075201.E

Enrollment and Change Form

Mark all boxes and complete all sections that apply. Return completed form to Human Resources.

APPLICANT	Your Name (Last, First, Middle)		Group Name City of Chicopee		Policy Number 146562	
	Address		City		State	Zip
	Social Security #		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title/Occupation	
LIFE	<p>Check with your Human Resources/Benefits Department about coverage options available to you and Evidence of Insurability requirements.</p> <p>Employee</p> <p><input type="checkbox"/> Basic Life/AD&D \$20,000 (50% Employee Paid)</p> <p><input type="checkbox"/> Additional Life \$20,000 (100% Employee Paid)</p>					
BENEFICIARY	<p>This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are NOT valid unless signed, dated, and delivered to your Employer during your lifetime. See page 2 for further information.</p>					
	Primary- Full Name		Address		Social Security #	Relationship
						% Benefit
	Contingent- Fill Name		Address		Social Security #	Relationship
						% Benefit
CHANGE	<p>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</p> <p><input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Other</p> <p>Date of Add/delete _____ Former name _____</p>					
SIGNATURE	<p>I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction will change if my coverage or costs change.</p>					
	Member/Employee Signature Required (Mo/Day/YR)					Date
Human Resources/Benefits Department- Complete this section. Retain form for your records						
Division	Billing Category	Date of Hire/Rehire	Hours Worked Per Week	Earnings		
				\$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	

Beneficiary Information

- * Your designation revokes all prior designations.
- * Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- * If you name two or more Beneficiaries in a class:
 1. Two or more Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- * If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. IF the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- * A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. Of you have any questions, consult your legal advisor
- * Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.



HNE Complete^{Plus} (HMO Option 7H)

HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Agreement, the terms of the Member Agreement apply.

- Note about Prior Approval:**

Some services require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Out-of-Pocket Maximum for Medical Services per Calendar Year (This applies to medical services with Copays of \$100 or more. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a Copay for these types of services for the rest of the year.)	\$1,000 per individual/\$2,000 per family

Benefit	Copay
Inpatient Care	
Acute Hospital Care and Inpatient Rehabilitation	\$500/admission
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	\$500/admission
Outpatient Preventive Care	
Adult Routine Exams	\$0
Well Child Care	\$0
Routine Eye Exams (limited to one per Calendar Year)	\$0
Annual Gynecological Exams (limit to one per Calendar Year)	\$0
Routine Mammograms	\$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	\$10/visit
Hearing Tests (in a PCP's office)	\$10/visit
Specialist Office Visits	\$25/visit
Second Opinions	\$25/visit
Diabetic-Related Items:	
Outpatient Services	\$25/visit
Lab/Radiological Services	\$0
Durable Medical Equipment (some DME requires Prior Approval; \$3,000 annual DME maximum applies)	20%
Individual Diabetic Education	\$25/visit
Group Diabetic Education	\$10/session
Emergency Room Care (Copay waived if admitted)	\$50/visit
Diagnostic Testing (some services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	\$25/visit

Benefit	Copay
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure & related prep prescriptions are subject to Copays)	\$0
Lab Services	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	\$0
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	\$25/visit/treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	\$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	\$25/visit
Outpatient Surgical Services and Procedures (Some services require Prior Approval. This Copay is based on the type of service, not where it is performed. To find out if this Copay applies to a specific procedure, please contact HNE Member Services.)	\$250/admission
Allergy Testing and Treatment	\$25/visit
Allergy Injections	\$0
Family Planning Services	
Office Visit	\$25/visit
Infertility Services	
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.	
Office Visit	\$25/visit
Outpatient Surgery/ Procedure	\$250/admission
Lab Test	\$0
Inpatient Care †	\$500/admission
Maternity Care	
Routine Prenatal and Postpartum Care	\$0
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	\$500/admission
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	\$25/visit
Emergency Dental Care in a Doctor's or Dentist's Office	\$25/visit
Emergency Dental Care in an Emergency Room	\$50/visit
Routine dental services for children under the age of 12. (For Out-of-Plan Providers, you pay the first \$25 per child per Calendar Year. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee)	\$0
Other Services	
Home Health Care †	\$0
Hospice Services †	\$0

Benefit	Copay
Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year benefit maximum)	20%
Prosthetic Limbs †	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	\$25/Member/day
Kidney Dialysis	\$0
Nutritional Support †	\$0
Cardiac Rehabilitation	\$25/visit
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year.)	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	\$25/visit
Nutritional Counseling (limited to four visits per Calendar Year)	\$25/visit
Human Organ Transplants and Bone Marrow Transplants †	\$500/admission
Behavioral Health	
Outpatient Services (Includes Mental Health and Substance Abuse) †	\$10/visit
Inpatient Mental Health Services †	\$500/admission
Inpatient Substance Abuse Services †	\$500/admission



HNE Choice^{Plus} (HMO Option 7M)

HMO Benefit Chart

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- Note about Prior Approval:**

Some services require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Out-of-Pocket Maximum for Medical Services per Calendar Year (This applies to medical services with Copays of \$100 or more. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a Copay for these types of services for the rest of the year.)	\$1,000 per individual/\$2,000 per family

Benefit	Copay
Inpatient Care	
Acute Hospital Care and Inpatient Rehabilitation	\$500/admission
Skilled Nursing Facility (limited to 100 days per Calendar Year) †	\$500/admission
Outpatient Preventive Care	
Adult Routine Exams	\$0
Well Child Care	\$0
Routine Eye Exams (limited to one per Calendar Year)	\$0
Annual Gynecological Exams (limited to one per Calendar Year)	\$0
Routine Mammograms	\$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	\$20/visit
Hearing Tests (in a PCP's office)	\$20/visit
Specialist Office Visits	\$40/visit
Second Opinions	\$40/visit
Diabetic-Related Items:	
Outpatient Services	\$40/visit
Lab/Radiological Services	\$0
Durable Medical Equipment (some DME requires Prior Approval; \$3,000 annual DME maximum applies)	20%
Individual Diabetic Education	\$40/visit
Group Diabetic Education	\$20/session
Emergency Room Care (Copay waived if admitted)	\$75/visit
Diagnostic Testing (some services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	\$40/visit

Benefit	Copay
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years, office visit Copay may apply if done in a doctor's office; office visits prior to the procedure & related prep prescriptions are subject to Copays)	\$0
Lab Services	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	\$0
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	\$40/visit/treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	\$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	\$40/visit
Outpatient Surgical Services and Procedures (Some services require Prior Approval. This Copay is based on the type of service, not where it is performed. To find out if this Copay applies to a specific procedure, please contact HNE Member Services.)	\$250/admission
Allergy Testing and Treatment	\$40/visit
Allergy Injections	\$0
Family Planning Services	
Office Visit	\$40/visit
Infertility Services	
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.	
Office Visit	\$40/visit
Outpatient Surgery/ Procedure	\$250/admission
Lab Test	\$0
Inpatient Care †	\$500/admission
Maternity Care	
Routine Prenatal and Postpartum Care	\$0
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	\$500/admission
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	\$40/visit
Emergency Dental Care in a Doctor's or Dentist's Office	\$40/visit
Emergency Dental Care in an Emergency Room	\$75/visit
Routine dental services for children under the age of 12. (For Out-of-Plan Providers, you pay the first \$25 per child per Calendar Year. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	\$0
Other Services	
Home Health Care †	\$0
Hospice Services †	\$0

Benefit	Copay
Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year benefit maximum)	20%
Prosthetic Limbs †	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	\$50/Member/day
Kidney Dialysis	\$0
Nutritional Support †	\$0
Cardiac Rehabilitation	\$40/visit
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year)	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	\$40/visit
Nutritional Counseling (limited to four visits per Calendar Year)	\$40/visit
Human Organ Transplants and Bone Marrow Transplants †	\$500/admission
Behavioral Health	
Outpatient Services (Includes Mental Health and Substance Abuse) †	\$20/visit
Inpatient Mental Health Services †	\$500/admission
Inpatient Substance Abuse Services †	\$500/admission



HNE Focus (HMO Option 8H)

HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Agreement, the terms of the Member Agreement apply.

- Note about Prior Approval:**

Some services require Prior Approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Out-of-Pocket Maximum for Medical Services per Calendar Year (This applies to medical services with Copays of \$100 or more. Once you have paid the Out-of-Pocket Maximum, you will not have to pay a Copay for these types of services for the rest of the year.)	\$2,000 per individual/\$4,000 per family

Benefit	Copay
Inpatient Care	
Acute Hospital Care and Inpatient Rehabilitation	\$1,000/admission
Skilled Nursing Facility † (limited to 100 days per Calendar Year)	\$1,000/admission
Outpatient Preventive Care	
Adult Routine Exams	\$0
Well Child Care	\$0
Routine Eye Exams (limited to one per Calendar Year)	\$0
Annual Gynecological Exams (limited to one per Calendar Year)	\$0
Routine Mammograms	\$0
Other Outpatient Care	
PCP Office Visit (Non-Routine)	\$25/visit
Hearing Tests (in a PCP's office)	\$25/visit
Specialist Office Visits	\$25/visit
Second Opinions	\$25/visit
Diabetic-Related Items:	
Outpatient Services	\$25/visit
Lab/Radiological Services	\$0
Durable Medical Equipment (some DME requires prior approval; \$3,000 annual DME maximum applies)	20%
Individual Diabetic Education	\$25/visit
Group Diabetic Education	\$25/session
Emergency Room Care (Copay waived if admitted)	\$100/visit
Diagnostic Testing (some services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	\$25/visit

Benefit	Copay
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure & related prep prescriptions are subject to Copays)	\$0
Lab Services	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	\$150
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	\$25/visit/treatment type
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	\$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	\$25/visit
Outpatient Surgical Services and Procedures (Some services require Prior Approval. This Copay is based on the type of service, not where it is performed. To find out if this Copay applies to a specific procedure, please contact HNE Member Services.)	\$500/admission
Allergy Testing and Treatment	\$25/visit
Allergy Injections	\$0
Family Planning Services	
Office Visit	\$25/visit
Infertility Services	
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.	
Office Visit	\$25/visit
Outpatient Surgery/ Procedure	\$500/admission
Lab Test	\$0
Inpatient Care †	\$1,000/admission
Maternity Care	
Routine Prenatal and Postpartum Care	\$0
Delivery/Hospital Care for Mother and Child (Coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)	\$1,000/admission
Dental Services	
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	\$25/visit
Emergency Dental Care in a Doctor's or Dentist's Office	\$25/visit
Emergency Dental Care in an Emergency Room	\$100/visit
Routine dental services for children under the age of 12. (For Out-of-Plan Providers, you pay the first \$25 per child per Calendar Year. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee)	\$0
Other Services	
Home Health Care †	\$0
Hospice Services †	\$0

Benefit	Copay
Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year benefit maximum)	20%
Prosthetic Limbs †	20%
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	\$50/Member/day
Kidney Dialysis	\$0
Nutritional Support †	\$0
Cardiac Rehabilitation	\$25/visit
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year.)	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)	\$25/visit
Nutritional Counseling (limited to four visits per Calendar Year)	\$25/visit
Human Organ Transplants and Bone Marrow Transplants †	\$1,000/admission
Behavioral Health	
Outpatient Services (Includes Mental Health and Substance Abuse) †	\$25/visit
Inpatient Mental Health Services †	\$1,000/admission
Inpatient Substance Abuse Services †	\$1,000/admission



HNE Essential^{Max} (HMO Option 9H)

HMO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Agreement, the terms of the Member Agreement apply.

- Note about Prior Approval:**

Some services require prior approval. These services are marked with † in the chart. If you do not obtain Prior Approval, benefits may be denied.

	In-Plan
Deductible per Year* (You must pay this amount for Covered Services before HNE will begin to pay benefits. As indicated in the chart below, some services are not subject to the Deductible.)	\$1,000 per individual/\$2,000 per family
Out-of-Pocket Maximum per Year* (This includes your Deductible and all medical services with a Copay of \$100 or more (including the Copay for Durable Medical Equipment (DME) and Prosthetics). Once you have met the Out-of-Pocket Maximum, you will not have to pay Copays for those services for the remainder of the year.)	\$2,000 per individual/\$4,000 per family
* May be based on a Calendar Year or a Policy Year basis. This depends on the Group through which you enroll.	

Benefit	Deductible Applies	Copay
Inpatient Care		
Acute Hospital Care and Inpatient Rehabilitation		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Skilled Nursing Facility † (limited to 100 days per Calendar Year)		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Outpatient Preventive Care		
Adult Routine Exams	No	\$0
Well Child Care	No	\$0
Child and Adult Routine Immunizations	No	\$0
Annual Gynecological Exams (limited to one per Calendar Year)	No	\$0
Routine Eye Exams (limited to one per Calendar Year)	No	\$0
Routine Mammograms (routine mammograms limited to one per Calendar Year)	No	\$0
Preventive Screenings Listed under "Outpatient Preventive Care" in the <i>Covered Benefits</i> Section of the EOC	No	\$0

Benefit	Deductible Applies	Copay
Other Outpatient Care		
PCP Office Visit (Non-Routine)	No	\$20/visit
Specialist Office Visits	No	\$40/visit
Second Opinions	No	\$40/visit
Diabetic-Related Items:		
Outpatient Physician Charges	No	\$40/visit
Outpatient Facility Charges	Yes	\$40/visit
Lab Services	No	\$0
Durable Medical Equipment (some DME requires Prior Approval; \$3,000 annual DME maximum applies)	No	20%
Group Diabetic Education	No	\$20/session
Emergency Room Care (Copay waived if admitted)	Yes	\$100/visit
Diagnostic Testing		
• Physician Charges	No	\$40/visit
• Facility Charges	Yes	\$0
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; office visit Copay may apply if done in a doctor's office; office visits prior to the procedure, related prep prescriptions and subsequent pathology are subject to applicable Deductible & Copays)	No	\$0
Lab Services	No	\$0
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans †	Yes	\$100
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)		\$40/visit per treatment type
• Physician Charges	No	
• Facility Charges	Yes	
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	Yes	\$25/day or half day
Early Intervention Services (Covered for children from birth to age 3.)	No	\$40/visit
Outpatient Surgical Services and Procedures (some services require Prior Approval; office visit Copay may apply if done in a doctor's office)		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Allergy Testing and Treatment		
• In a Doctor's office	No	\$40/visit
• In a Facility	Yes	\$40/visit
Allergy Injections		
• In a Doctor's Office	No	\$0
• In a Facility	Yes	\$0

Benefit	Deductible Applies	Copay
Hearing Tests		
• In a PCP Office	No	\$20/visit
• In a Specialist Office	No	\$40/visit
• In a Facility	Yes	\$0
Family Planning Services		
Office Visit	No	\$40/visit
Infertility Services		
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.		
Office Visit	No	\$40/visit
Outpatient Surgery/ Procedure †		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Lab Test	No	\$0
Inpatient Care †		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Maternity Care		
Non-Routine Prenatal and Postpartum Care	No	\$40/visit
Delivery/Hospital Care for Mother and Child (coverage for child limited to routine newborn nursery charges. For continued coverage, child must be enrolled within 31 days of date of birth)		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Dental Services		
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	No	\$40/visit
Emergency Dental Care in a Doctor's or Dentist's Office	No	\$40/visit
Emergency Dental Care in an Emergency Room	Yes	\$100/visit
Routine dental services for children under the age of 12. (A separate \$25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee.)	No	\$0
Other Services		
Home Health Care †	Yes	\$0
Hospice Services †	No	\$0
Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year benefit maximum)	No	20%
Prosthetic Limbs †	No	\$0
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval)	Yes	\$100/Member/day
Kidney Dialysis	No	\$0
Nutritional Support †	No	\$0

Benefit	Deductible Applies	Copay
Cardiac Rehabilitation		\$40/visit
• Physician Charges	No	
• Facility Charges	Yes	
Wigs (Scalp Hair Protheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year)	No	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation.)		\$40/visit
• Physician Charges	No	
• Facility Charges	Yes	
Nutritional Counseling (limited to four visits per Calendar Year)	No	\$40/visit
Human Organ Transplants and Bone Marrow Transplants †		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Behavioral Health		
Outpatient Services (Includes Mental Health and Substance Abuse) †	No	\$20/visit
Inpatient Mental Health Services †	No	
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0
Inpatient Substance Abuse Services †		
• Physician Charges	No	\$0
• Facility Charges	Yes	\$0



HNE PPO Premium PHCS PPO Benefit Chart

This chart provides a summary of key services offered by your plan. Consult your Member Agreement for a full description of your plan's benefits and provisions. If any terms in this summary differ from those in your Member Agreement, the terms of the Member Agreement apply.

- **Please note:** When you receive services from an Out-of-Plan Provider, you are also responsible for any Remaining Balances. A Remaining Balance is that portion of an Out-of-Plan Provider's charge that is above HNE's Maximum Allowable Fee.
- **Note about Prior Approval:**
Some services require Prior Approval. These services are marked with † in the chart. In some cases, if you fail to ask for Prior Approval, the service will not be covered at all. (See, for example, Infertility Treatment below.) In other cases, for example Acute Hospital Care at an Out-of-Plan facility, if you fail to ask for Prior Approval, you may have a Reduction of Benefit up to the amount indicated below. Remember that exclusions or limitations of this plan still apply, even if you ask for Prior Approval. For example, services that are not Medically Necessary are not covered, even if you ask for Prior Approval.

	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Deductible per Calendar Year (You must pay this amount for Covered Services from Out-of-Plan Providers before HNE will begin to pay benefits.)	Not applicable	Not applicable	\$250 per individual/\$500 per family
Maximum Responsibility for Inpatient Care and Outpatient Surgical Services and Procedures Copays per Calendar Year	\$200 per individual/\$400 per family	\$500 per individual/\$1,000 per family	Not applicable
Coinsurance Maximum per Calendar Year	Not applicable	Not applicable	\$1,000 per individual/\$2,000 per family
Reduction of Benefit (Applies to certain services if Prior Approval is required but not requested.)	N/A	\$250	\$250

Benefit	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Inpatient Care			
Acute Hospital Care and Inpatient Rehabilitation † (elective admission to Out-of-Plan facilities require Prior Approval)	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Skilled Nursing Facility † (limited to 100 days per Calendar Year; admissions to Out-of-Plan facilities require Prior Approval)	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit

Benefit	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Outpatient Preventive Care			
Adult Routine Exams	\$0	\$0	Deductible + 20%
Well Child Care	\$0	\$0	Deductible + 20%
Routine Eye Exams (limited to one per Calendar Year)	\$0	\$0	Deductible + 20%
Annual Gynecological Exams (limited to one per Calendar Year)	\$0	\$0	Deductible + 20%
Other Outpatient Care			
Physician Office Visit	\$10/visit	\$20/visit	Deductible + 20%
Hearing Tests	\$10/visit	\$20/visit	Deductible + 20%
Diabetic-Related Items:			
Outpatient Services	\$10/visit	\$20/visit	Deductible + 20%
Lab/Radiological Services	\$0	\$0	Deductible + 20%
Durable Medical Equipment (some DME requires Prior Approval; \$3,000 annual DME maximum applies)	20%	20% & if Prior Approval was required & not requested, up to \$250 Reduction of Benefit	Deductible + 20% & if Prior Approval was required & not requested, up to \$250 Reduction of Benefit
Individual Diabetic Education	\$10/visit	\$20/visit	Deductible + 20%
Group Diabetic Education	\$10/session	\$20/session	Deductible + 20%
Second Opinions	\$10/visit	\$20/visit	Deductible + 20%
Emergency Room Care (Copoly waived if admitted)	\$75/visit	\$75/visit	\$75/visit
Diagnostic Testing (some In-Plan services are subject to the Outpatient Surgical Services and Procedure Copay; see Outpatient Surgical Services and Procedures below)	\$10/visit	\$20/visit	Deductible + 20%
Screening Colonoscopy or Sigmoidoscopy (limited to one every five Calendar Years; an office visit Copay may apply if done in an In-Plan doctor's office; office visits prior to the procedure & related prep prescriptions are subject to Copays)	\$0	\$0	Deductible + 20%
Lab Services	\$0	\$0	Deductible + 20%
Radiological Services: Ultrasound, X-rays, Nuclear Cardiology, Non-Routine Mammograms	\$0	\$0	Deductible + 20%
Diagnostic Imaging: CT Scans, MRIs, MRAs, PET Scans	\$0 (If Prior Approval is denied, Member is responsible for all costs)	\$0 (Without Prior Approval, Member pays all costs)	Deductible + 20% (Without Prior Approval, Member pays all costs)
Outpatient Short-Term Rehabilitation Services (limited to two months or 25 visits, whichever is greater, per condition per Calendar Year for physical or occupational therapy)	\$10/visit/treatment type	\$20/visit/treatment type	Deductible + 20%

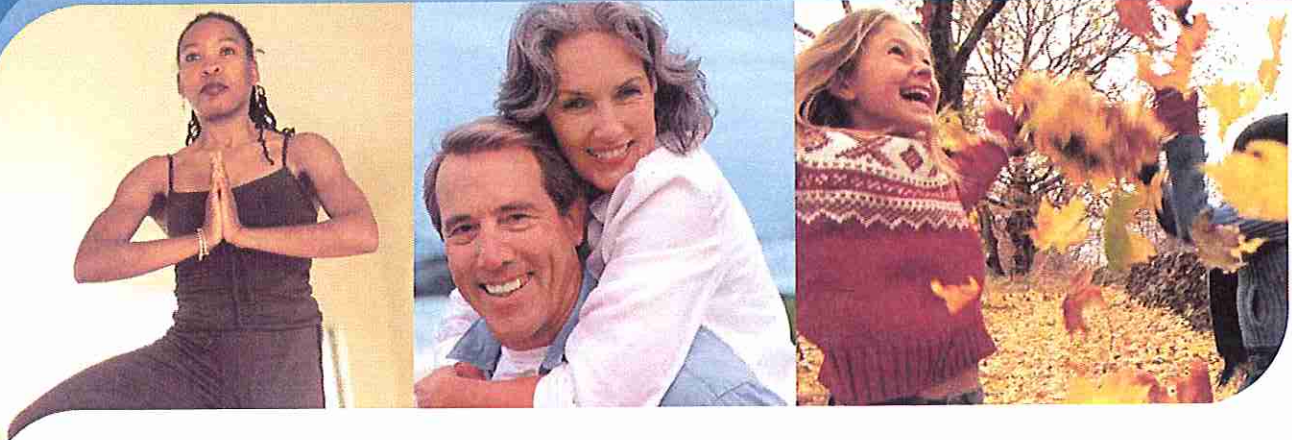
Benefit	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Day Rehabilitation Program (limited to 15 full day or ½ day sessions per condition per lifetime)	\$25/day or half day	\$50/day or half day	Deductible + 20%
Early Intervention Services (Covered for children from birth to age 3.)	\$10/visit	\$20/visit	Deductible + 20%
Outpatient Surgical Services and Procedures (Some services require Prior Approval. The In-Plan Copay is based on the type of service, not where it is performed. To find out if this Copay applies to a specific procedure, please contact HNE Member Services.)	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% and up to \$250 Reduction of Benefit
Allergy Testing and Treatment	\$10/visit	\$20/visit	Deductible + 20%
Allergy Injections	\$0	\$0	Deductible + 20%
Family Planning Services			
Office Visit	\$10/visit	\$20/visit	Deductible + 20%
Infertility Services			
Some Infertility services are covered only for Massachusetts residents and for Connecticut residents under the age of 40. Some services require Prior Approval.			
Office Visit	\$10/visit	\$20/visit (if Prior Approval not requested, Member pays all costs)	Deductible + 20% (if Prior Approval not requested, Member pays all costs)
Outpatient Surgery/ Procedure	\$100/admission	\$250/admission (if Prior Approval not requested, Member pays all costs)	Deductible + 20% (if Prior Approval not requested, Member pays all costs)
Lab Test	\$0	\$0 (if Prior Approval not requested, Member pays all costs)	Deductible + 20% (if Prior Approval not requested, Member pays all costs)
Inpatient Care†	\$100/admission	\$250/admission (if Prior Approval not requested, Member pays all costs)	Deductible + 20% (if Prior Approval not requested, Member pays all costs)
Maternity Care			
Routine Prenatal and Postpartum Care	\$0	\$0	Deductible + 20%
Delivery/Hospital Care for Mother and Child (For continued coverage, child must be enrolled within 31 days of date of birth)	\$100/admission	\$250/admission	Deductible + 20%
Dental Services			
Surgical Treatment of Non-Dental Conditions in a Doctor's Office (Some services are subject to the Outpatient Surgical Services and Procedures Copay.)	\$10/visit	\$20/visit	Deductible + 20%

Benefit	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Emergency Dental Care in a Doctor's or Dentist's Office	\$10/visit	\$20/visit	Deductible + 20%
Emergency Dental Care in an Emergency Room	\$75/visit	\$75/visit	\$75/visit
Routine dental services for children under the age of 12. (A separate \$25 per child per Calendar Year deductible applies only to services from Out-of-Plan dentists. Out-of-Plan dentists may also bill you for the difference between their charge and HNE's contracted dental network Maximum Allowable Fee)	\$0 for services from a dentist participating with HNE's contracted dental network	\$0 for services from a dentist participating with HNE's contracted dental network	You pay the first \$25 per child per Calendar Year
Other Services			
Home Health Care †	\$0	\$0 & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Hospice Services †	\$0	\$0 & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Durable Medical Equipment (some items require Prior Approval; \$3,000 per Calendar Year benefit maximum)	20%	20% & if Prior Approval was required & not requested, up to \$250 Reduction of Benefit	Deductible + 20% & if Prior Approval was required & not requested, up to \$250 Reduction of Benefit
Prosthetic Limbs †	20%	20% (Without Prior Approval, Member pays all costs)	Deductible + 20% (Without Prior Approval, Member pays all costs)
Ambulance and Transportation Services (non-emergency transportation requires Prior Approval; if Prior Approval is not obtained for non-emergency transportation, Member pays all costs)	\$50/Member/day	\$50/Member/day	\$50/Member/day
Kidney Dialysis	\$0	\$0	Deductible + 20%
Nutritional Support † (not covered without Prior Approval)	\$0	\$0	\$0
Cardiac Rehabilitation	\$10/visit	\$20/visit	Deductible + 20%
Wigs (Scalp Hair Prostheses) for hair loss due to treatment of any form of cancer or leukemia. (HNE pays up to \$350 per Calendar Year)	\$0	\$0	\$0
Speech, Hearing, and Language Disorders † (Prior Approval is required for speech therapy services after the initial evaluation visit.)	\$10/visit	\$20/visit & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Nutritional Counseling (limited to four visits per Calendar Year)	\$10/visit	\$20/visit	Deductible + 20%

Benefit	In-Plan Providers		Out-of-Plan Providers
	HNE Providers	PHCS Providers	
Human Organ Transplants and Bone Marrow Transplants † (Without Prior Approval, payments you make to Out-of-Plan Providers for Deductible and Coinsurance do not count toward your Deductible or Maximum Coinsurance amounts.)	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Behavioral Health			
Outpatient Services (Includes Mental Health and Substance Abuse) †	\$10/visit	\$20/visit	Deductible + 20%
Inpatient Mental Health Services †	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit
Inpatient Substance Abuse Services †	\$100/admission	\$250/admission & up to \$250 Reduction of Benefit	Deductible + 20% & up to \$250 Reduction of Benefit



MASSACHUSETTS



HMO Blue[®] Value Plus

\$10/\$20 Office Visit and
\$50 Emergency Room Copayment Option

Summary of Benefits

City of Chicopee

✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that will be effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

Your Care

Your Primary Care Physician.

When you join HMO Blue, you must choose a primary care physician (PCP) for you and each member of your family. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the *HMO Blue Provider Directory*; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care—Wherever You Are* for emergency care services). Your HMO Blue PCP cares about your health, which is why, should you and your PCP decide you need a specialist, you'll be referred to the one your PCP determines is appropriate for treating your specific condition. Of course, if you have a specialist to whom you would like to be referred, discuss this with your doctor. It's an important decision and the top priority is keeping you healthy. Your physician may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificate.

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). There is a \$50 copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay.

HMO Blue Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. Please see your subscriber certificate for a complete definition of the service area.

When Outside the HMO Blue Service Area.

If you're traveling outside the service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your subscriber certificate for more information.

Out-of-Pocket Maximum for Certain Copayments.

You're protected by an out-of-pocket maximum of \$1,000 for a member in a calendar year (or \$2,000 per family). Only copayments for hospital admissions, ambulatory surgery admissions, and emergency room services will be applied to your out-of-pocket maximum. You will still have to pay any costs that are not included in the out-of-pocket maximum.

Dependent Benefits.

This plan covers dependents to age 26, or for two calendar years after the dependent last qualified as a dependent under the Internal Revenue Code, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost
Outpatient Care	
Emergency room visits	\$50 per visit (waived if admitted or for observation stay)
Well-child care visits	\$10 per visit (no cost for immunizations and routine tests)
Routine adult physical exams, including related tests	\$10 per visit (no cost for routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	\$10 per visit (no cost for routine tests)
Routine hearing exams	\$10 per visit
When performed by your PCP or network nurse practitioner	\$20 per visit
When performed by other network providers	
Routine vision exams (one per calendar year)	\$20 per visit
Family planning services—office visits	\$10 per visit
Office visits	
When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife	\$10 per visit
When performed by other network providers	\$20 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$10 per visit
Allergy injections only	Nothing
Diagnostic X-rays, lab tests, and other tests	Nothing
Home health care, including hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Preventive dental care for children under age 12 (one visit each six months)	Nothing
Durable medical equipment and repairs—such as wheelchairs, crutches, hospital beds (up to a \$750 per calendar year**)	All charges beyond the calendar-year benefit maximum
Prosthetic devices	20% of approved charges
Ambulatory surgery	\$500 per admission***
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$500 per admission***
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing
Prescription Drug Benefits	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$10 for Tier 1 \$20 for Tier 2 \$35 for Tier 3

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.

** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

*** Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed \$500.

Your Medical Benefits (continued)

Covered Services	Your Cost
Mental Health and Substance Abuse Treatment	
Biologically based conditions*	
Inpatient admissions in a general hospital or mental hospital	\$500 per admission**
Outpatient visits	\$10 per visit
Non-biologically based mental conditions (includes drug addiction and alcoholism)	
Inpatient admissions in a general hospital	\$500 per admission**
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	\$500 per admission**
Outpatient visits (up to 24 visits per calendar year)	\$10 per visit
Alcoholism treatment (in addition to non-biologically based mental conditions)	
Inpatient admissions in a general hospital	\$500 per admission**
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	\$500 per admission**
Outpatient visits (up to 8 visits per calendar year***)	\$10 per visit

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 are covered to the same extent as biologically based conditions.

** Copayments for consecutive inpatient admissions (or day surgery followed by inpatient care) within 30 days for the same or related illness will not exceed \$500.

*** The value of these visits is at least \$500 in each calendar year.

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you Healthy Blue, a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at 1-800-932-8323 to receive our *Healthy Blue* booklet, which outlines these special programs.

LIVING HEALTHY <i>Babies</i> SM	No charge
A Fitness Benefit toward membership at a health club (see your subscriber certificate for details)	\$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	\$150 per year, per individual/family
Living Healthy SM Vision—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Discounts on safety helmets and home safety items	Discount varies
Blue Care SM Line to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No charge
Living Healthy SM Naturally—discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No charge

Questions? Call 1-800-932-8323.

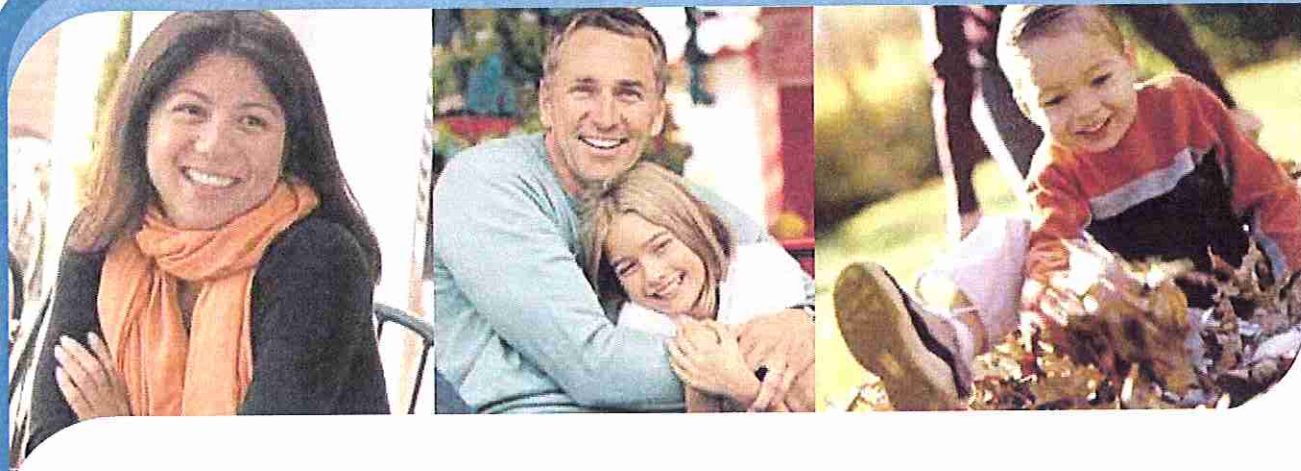
For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: chiropractic services; cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.





MASSACHUSETTS



HMO Blue OptionsSM v.2

Summary of Benefits

✓ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that will be effective January 1, 2009, as part of the Massachusetts Health Care Reform Law.

Your Care

Within the HMO Blue Options network, hospitals and groups of primary care physicians (PCPs) are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier providers each time you get hospital or PCP care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes Massachusetts PCPs and hospitals that met our quality benchmark and our benchmark for lowest cost.
- **Standard Benefits Tier**—Includes Massachusetts PCPs and hospitals that met our quality benchmark and our benchmark for moderate cost. Also includes providers without sufficient data for measurement on one or both benchmarks. In limited circumstances, the Standard Benefits Tier includes certain providers whose scores would put them in the Basic Benefits Tier to provide geographic access for members.
- **Basic Benefits Tier**—Includes Massachusetts PCPs and hospitals that scored below our quality benchmark and/or our benchmark for moderate cost.

Note: For the cost benchmark, hospitals were measured on their individual facility's performance and PCPs were measured according to the costs their group's HMO patients incurred. Physician groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on benchmarks where measurable data is available; those without sufficient data were defaulted to the Standard Benefits Tier. Specialty hospitals were measured on cost alone for their overall tier rating. Hospitals with nonstandard reimbursement were placed in the Basic Benefits Tier.

It is important to consider the tier of both your primary care physician and the facility where your physician has admitting privileges before you choose a PCP or receive care. For example, if you require hospital care and your Enhanced Benefits Tier PCP refers you to an Enhanced Benefits Tier hospital, you would pay the lowest cost sharing for both your PCP and hospital services. Or, if your Enhanced Benefits Tier PCP refers you to a Basic Benefits Tier hospital for care, you will pay the lowest copayments for PCP services, but the highest copayments for hospital services, except in an emergency.

Your Primary Care Physician.

When you enroll, you must choose a PCP for you and each member of your family. There are several ways to find a PCP or find the tier designation of a PCP (or general hospital): visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com; consult the *HMO Blue Options v.2 Provider Directory*; or call our Physician Selection Service at 1-800-821-1388. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care—Wherever You Are* for emergency care services). Your PCP cares about your health. This is why, should you and your PCP decide you need a specialist, you'll be referred to the one your PCP determines is appropriate for treating your specific condition. Of course, if you have a specialist to whom you would like to be referred, discuss this with your doctor. It's an important decision and the top priority is keeping you healthy. Your physician may also work with Blue Cross Blue Shield of Massachusetts concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your subscriber certificate.

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). You pay a \$100 copayment per visit for emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital. Any follow-up care must be arranged by your PCP.

HMO Blue Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts. Please see your subscriber certificate for exact service area details.

When Outside the HMO Blue Service Area.

If you're traveling outside the service area and you need urgent or emergency care, you may go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your subscriber certificate for more information.

Dependent Benefits.

This plan covers dependents to age 26, or for two calendar years after the dependent last qualified as a dependent under the Internal Revenue Code, whichever comes first. Additionally, this plan may cover unmarried full-time students or other unmarried dependents who do not otherwise qualify as eligible dependents. Please see your subscriber certificate (and riders, if any) for exact coverage details.

Your Medical Benefits

Covered Services	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Outpatient Care			
Emergency room visits	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit (waived if admitted or for observation stay)	\$100 per visit (waived if admitted or for observation stay)
Well-child care visits	\$15 per visit (no cost for immunizations and routine tests)	\$25 per visit (no cost for immunizations and routine tests)	\$45 per visit (no cost for immunizations and routine tests)
Routine adult physical exams, including related tests	\$15 per visit (no cost for immunizations and routine tests)	\$25 per visit (no cost for immunizations and routine tests)	\$45 per visit (no cost for immunizations and routine tests)
Routine GYN exams, including related lab tests (one per calendar year)	\$15 per visit (no cost for routine tests)	\$15 per visit (no cost for routine tests)	\$15 per visit (no cost for routine tests)
Office visits			
• PCP, network nurse practitioner, or nurse midwife (billed by PCP)	\$15 per visit	\$25 per visit	\$45 per visit
• Network nurse practitioner or nurse midwife (not billed by PCP)	\$15 per visit	\$15 per visit	\$15 per visit
• Other network providers	\$45 per visit	\$45 per visit	\$45 per visit
Routine hearing exams			
• PCP	\$15 per visit	\$25 per visit	\$45 per visit
• Other network providers	\$45 per visit	\$45 per visit	\$45 per visit
Routine vision exam (one every 24 months)	\$45 per visit	\$45 per visit	\$45 per visit
Family planning services—office visits			
• PCP	\$15 per visit	\$25 per visit	\$45 per visit
• Other network providers	\$45 per visit	\$45 per visit	\$45 per visit
Chiropractor services (up to 12 visits per calendar year for members age 16 or older)	\$45 per visit	\$45 per visit	\$45 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$45 per visit	\$45 per visit	\$45 per visit
Speech, hearing, and language disorder treatment—speech therapy	\$45 per visit	\$45 per visit	\$45 per visit
Allergy injections only	Nothing	Nothing	Nothing
Home health care and hospice services	Nothing	Nothing	Nothing
Oxygen and equipment for its administration	Nothing	Nothing	Nothing
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, and PET scans	Nothing	Nothing	Nothing
CT scans, MRIs, and PET scans			
• General hospitals	\$75 per category per date of service	\$150 per category per date of service	\$250 per category per date of service
• Other covered providers	\$75 per category per date of service	\$75 per category per date of service	\$75 per category per date of service
Prosthetic devices	20% co-insurance	20% co-insurance	20% co-insurance
Durable medical equipment—such as wheelchairs, crutches, and hospital beds (up to \$750 per calendar year**)	All charges beyond the calendar-year benefit maximum	All charges beyond the calendar-year benefit maximum	All charges beyond the calendar-year benefit maximum
Surgery and related anesthesia			
• Office setting: PCP/Other network providers	\$15 per visit/\$45 per visit	\$25 per visit/\$45 per visit	\$45 per visit/\$45 per visit
• Surgical day care unit	\$150 per admission	\$250 per admission	\$500 per admission
• Ambulatory surgical facility	\$150 per admission	\$150 per admission	\$150 per admission
Inpatient Care (and maternity care)			
General hospital care (as many days as medically necessary)	\$250 per admission	\$500 per admission/\$300 per admission at selected hospitals***	\$1,000 per admission
Chronic disease hospital care (as many days as medically necessary)	\$250 per admission	\$250 per admission	\$250 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	Nothing	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	Nothing	Nothing

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care.

** No dollar limit applies when durable medical equipment is furnished as part of covered home dialysis, home health care, or hospice services.

*** To provide geographic access to members, the lower Standard Benefits Tier copayment applies for BHS Franklin Medical Center, Brockton Hospital, Cooley Dickinson Hospital, Falmouth Hospital, Martha's Vineyard Hospital, Nantucket Cottage Hospital, and North Adams Regional Hospital.

Your Medical Benefits (continued)

Covered Services	Your Cost for Enhanced Benefits Tier Network Providers	Your Cost for Standard Benefits Tier Network Providers	Your Cost for Basic Benefits Tier Network Providers
Mental Health and Substance Abuse Treatment			
Biologically based conditions* Inpatient admissions in a general hospital	\$250 per admission	\$500 per admission/\$300 per admission at selected hospitals**	\$1,000 per admission
Inpatient admissions in a mental hospital or substance abuse treatment facility	\$250 per admission	\$250 per admission	\$250 per admission
Outpatient services	\$15 per visit	\$15 per visit	\$15 per visit
Non-biologically based mental conditions (includes drug addiction and alcoholism) Inpatient admissions in a general hospital	\$250 per admission	\$500 per admission/\$300 per admission at selected hospitals**	\$1,000 per admission
Inpatient admissions in a mental hospital or substance abuse treatment facility (up to 60 days per calendar year)	\$250 per admission	\$250 per admission	\$250 per admission
Outpatient visits (up to 24 visits per calendar year)	\$15 per visit	\$15 per visit	\$15 per visit
Alcoholism treatment (in addition to non-biologically based mental conditions) Inpatient admissions in a general hospital	\$250 per admission	\$500 per admission/\$300 per admission at selected hospitals**	\$1,000 per admission
Inpatient admissions in a substance abuse treatment facility (up to 30 days per calendar year)	\$250 per admission	\$250 per admission	\$250 per admission
Outpatient visits (up to 8 visits per calendar year***)	\$15 per visit	\$15 per visit	\$15 per visit
Prescription Drug Benefits			
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	\$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3	\$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3	\$15 for Tier 1 \$30 for Tier 2 \$50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	\$30 for Tier 1 \$60 for Tier 2 \$150 for Tier 3	\$30 for Tier 1 \$60 for Tier 2 \$150 for Tier 3	\$30 for Tier 1 \$60 for Tier 2 \$150 for Tier 3

* Treatment for rape-related mental or emotional disorders and treatment for children under age 19 are covered to the same extent as biologically based conditions.

** To provide geographic access to members, the lower Standard Benefits Tier copayment applies for BHS Franklin Medical Center, Brockton Hospital, Cooley Dickinson Hospital, Falmouth Hospital, Martha's Vineyard Hospital, Nantucket Cottage Hospital, and North Adams Regional Hospital.

*** The value of these visits is at least \$500 in each calendar year.

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you Healthy Blue, a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at 1-800-262-BLUE (2583) to receive our *Healthy Blue* booklet, which outlines these special programs.

Living Healthy Babies®	No charge
A Fitness Benefit toward membership at a health club (see your subscriber certificate for details)	\$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	\$150 per year, per individual/family
Living Healthy® Vision—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Discounts on safety helmets and home safety items	Discount varies
Blue Care® Line to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No charge
Living Healthy® Naturally—discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No charge

Questions? Call 1-800-262-BLUE (2583).

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at www.bluecrossma.com.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

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EyeMed

VISION CARE®

CITY OF CHICOPEE

CITY OF CHICOPEE has selected EyeMed as your vision wellness program. This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. The plan is available through thousands of provider locations participating on the EyeMed ADVANTAGE network.

To see a list of participating providers near you, go to www.enrollwitheyemed.com and choose ADVANTAGE from the provider locator dropdown box. You can also call 1-866-203-7437.

Enroll today to take advantage of an affordable way to help ensure a lifetime of healthy vision.

Vision Care Services	Member Cost	Out-of-Network Reimbursement
Frames:	\$0 Copay, \$140 Allowance; 20% off balance over \$140	Up to \$82
Standard Plastic Lenses:		
Single Vision	\$10 Copay	Up to \$42
Bifocal	\$10 Copay	Up to \$78
Trifocal	\$10 Copay	Up to \$130
Standard Progressive	\$70	Up to \$78
Premium Progressive	\$70, 80% of Charge less \$110 Allowance	Up to \$78
Lens Options (paid by the member and added to the base price of the lens):		
Tint (Solid and Gradient)	\$0	Up to \$10
UV Coating	\$12	N/A
Standard Scratch-Resistance	\$0	Up to \$10
Standard Polycarbonate	\$35	N/A
Standard Polycarbonate for Children under 19	\$0	Up to \$26
Standard Anti-Reflective	\$40	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	30% off retail price	N/A
Contact lenses (allowance covers materials only):		
Conventional	\$0 Copay, \$155 Allowance; 15% off balance over \$155	Up to \$94
Disposables	\$0 Copay, \$155 Allowance; balance over \$155	Up to \$94
Medically Necessary	\$0 Copay, Paid in Full	Up to \$200
LASIK and PRK Vision Correction Procedures:	15% off retail price OR 5% off promotional pricing	N/A
Additional Pairs:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Frames	Once every 12 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

Additional Purchases and Out-of-Pocket Discount

Member will receive a 30% discount on remaining balance at Participating Providers beyond plan coverage; the discount does not apply to EyeMed's Providers' professional services or disposable contact lenses. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy; or Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive Lens not covered - fund as a Bifocal Lens. Standard Progressive Lens covered - fund Premium Progressive as a Standard. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9059. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Value Added Features:

In addition to the health benefits your EyeMed program offers, members also enjoy additional value-added features including:

- **Eye Care Supplies** - Receive 30% off retail price for eye care supplies like cleaning cloths and solutions purchased at network providers (not valid on doctor's services or contact lenses).
- **Laser Vision Correction** - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures.
- **Replacement Contact Lens Purchases** - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

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